Dear Referral Source:

Thank you for your interest in the Los Angeles County Department of Mental Health Assisted Outpatient Treatment (AOT) Program. Before completing the referral form, please review the following:

Completing the Referral Form

Please complete the form fully to your best ability.

If you are the person completing the application, please complete all sections of the form and write legibly. If you are uncertain of any section, you may enter "Unknown", “N/A,” or "0" if applicable. Do not leave any sections blank. Incomplete referrals will not be processed.

According to the statute governing AOT, the mental health provider completing the referral form MUST BE LICENSED or the referral will be disqualified. If you are not licensed, please include the name of a licensed clinician (i.e. your clinical supervisor) who is familiar with the case and gives consent. Please include your discipline (PhD, LMFT, LCSW, etc.)

Attach the following:

- **Any supporting documentation**
- **Photo (if homeless and a photo is available)**

Please Keep in Mind:

- A member of the AOT team may need to communicate with you directly (typically by phone) in order to gather additional information needed to determine referral eligibility. If the AOT investigator is unable to reach you, the referral will not be accepted. So please provide a contact number/email address where AOT staff can reach you. Please note that if you receive calls originating from County of Los Angeles cell phones may appear as 'Restricted' or ‘Blocked’.

- An appropriate AOT referral would be for an individual who is refusing all forms of mental health services. If the individual is participating in some form of mental health services, the AOT referral would be deemed inappropriate. (i.e. if the individual is going to appointments but not taking medications, the referral to AOT is not appropriate. AOT cannot mandate medication.)

- AOT is unable to accept referrals for individuals whose location is unknown. You must have some idea of the potential client’s location (specific corner, facility, etc.). You must also provide AOT with a picture for clients who cannot be identified by the referral party or a collateral.

CONFIDENTIAL

Please note that the AOT Program does not have the authority to mandate medication or involuntary long-term hospitalization/conservatorship.

Please fax completed form to (213) 402-3043 or email AOTLAOE@dmh.lacounty.gov for more information call (213) 738-2440.

IF THIS IS A PSYCHIATRIC EMERGENCY PLEASE CALL LACDMH Help Line 1-800-854-7771, DIAL 988, or 911

INSUFFICIENT DETAILS MAY DELAY THE REFERRAL PROCESS

Attach recent photo here

REFERRING PARTY INFORMATION

DATE OF SUBMISSON: _____

NAME OF REFERRING PARTY: _____

PHONE: _____

EMAIL: _____

IF APPLICABLE, AGENCY NAME: _____

PROGRAM NAME (i.e. FSP, OTT, MET etc.): _____

WHAT IS YOUR QUALIFYING RELATIONSHIP TO THE CANDIDATE?

PARENT, SPOUSE, SIBLING, ADULT CHILD-DESCRIBE _____

ADULT RESIDING WITH CANDIDATE-DESCRIBE _____

DIRECTOR OF TREATING AGENCY WHERE CANDIDATE RECEIVES MENTAL HEALTH SERVICES WHILE RESIDING AT FACILITY/HOSPITAL

CLIENT IS CURRENTLY ADMITTED TO-DESCRIBE _____

CANDIDATE'S CURRENT LICENSED MENTAL HEALTH TREATMENT PROVIDER-LICENSE TYPE _____

- IF CURRENTLY UNLICENSED, PROVIDE NAME OF LICENSED SUPERVISOR & THEIR TYPE OF LICENSE _____

PEACE OFFICER, PAROLE OFFICER, OR PROBATION OFFICER

SUPERIOR COURT JUDGE

*IF ACCEPTED TO THE PROGRAM IS THERE A PERSON THAT CAN ASSIST THE TEAM WITH LOCATING/GAINING ACCESS TO THE INDIVIDUAL, IF SO PLEASE PROVIDE INDIVIDUAL'S NAME & PHONE NUMBER: _____

**IF YOU ASSISTED THE REFERRING PARTY WITH COMPLETING THE FORM, PLEASE PROVIDE YOUR NAME & PHONE NUMBER: _____

CANDIDATE INFORMATION

NAME: _____ ALIAS: _____ DOB: _____ SSN: _____ DMH IBHIS: _____

GENDER: ☐FEMALE ☐MALE TRANSGENDER: ☐MTF ☐FTM ☐NON BINARY PREFERRED LANGUAGE: _____ HEIGHT: ____ WEIGHT: ____ HAIR COLOR: ____ EYE COLOR: ____

CANDIDATE PHONE: _____ ADDRESS OR CROSS STREET WHERE CANDIDATE TYPICALLY RESIDES: _____ CITY: _____ ZIP: _____

CURRENT DWELLING SITUATION AT TIME OF REFERRAL	RACE	INSURANCE (CHECK ALL THAT APPLY)	BENEFITS
☐ HOMELESS ☐HOTEL/MOTEL ☐ SHELTER ☐ HOSPITAL ☐LIVING INDEPENDENTLY ☐LIVING WITH FAMILY/NON-RELATIVE ADULT ☐SOBER LIVING ☐ BOARD AND CARE ☐RESIDENTIAL (SUBSTANCE) ☐ERS ☐CRTP ☐ SRO ☐ IMD ☐ JAIL ☐SUPPORTED HOUSING(i.e. ODR HOUSING)IF APPLICABLE NAME OF FACILITY:	☐AFRICAN AMERICAN/BLACK ☐ ASIAN ☐NATIVE AMERICAN/ALASKAN NATIVE ☐HAWAIIAN/OTH PACIFIC ISLANDER ☐ MULTIRACIAL ☐WHITE/CAUCASIAN ☐UNKNOWN ETHNICITY ☐HISPANIC/LATINO ☐NOT HISPANIC/LATINO ☐UNKNOWN	☐MEDI-CAL ☐MEDICARE ☐PRIVATE ☐VHA/TRICARE ☐NONE ☐UNKNOWN	☐ GR ☐ SSI ☐ SSDI ☐ EMPLOYED ☐ OTHER INCOME ☐ NONE

☐REGIONAL CENTER CLIENT REGIONAL CENTER OFFICE ASSIGNED TO: _____ ☐CANDIDATE SERVED IN THE MILITARY ☐CANDIDATE IS AN ENROLLED STUDENT

CURRENTLY CONSERVED: ☐LPS ☐PROBATE CONSERVATOR NAME &PHONE: _____ ☐PAST CONSERVATORSHIP ☐PENDING CONSERVATORHSIP HEARING

Client IBHIS #

	CANDIDATE HISTORY/CURRENT PRESENTATION	

IS CANDIDATE ON: PROBATION PAROLE NON-REVOCABLE PAROLE (does not report to parole agent) NAME OF OFFICER & PHONE: _____

CANDIDATE CURRENTLY HAS AN OPEN/VOLUNTARY CASE WITH DCFS

HIGH RISK: HISTORY/ACCESS TO WEAPONS HISTORY OF FIRE SETTING REGISTERED SEX OFFENDER SUICIDE ATTEMPT(S)

SUBSTANCE: PAST SUBSTANCE USE (SOBRIETY MORE THAN 30 DAYS) NEVER USED IN LAST 12 MONTHS, PARTICIPATED IN SUBSTANCE ABUSE TREATMENT
IN PAST 12 MONTHS, COMPLETED SUBSTANCE ABUSE TREATMENT

MENTAL HEALTH: IS THE CANDIDATE CURRENTLY RECEIVING MENTAL HEALTH SERVICES? YES NO IF YES, AGENCY NAME: _____ PROGRAM: _____

PHONE: _____

TYPE OF SERVICES BEING PROVIDED: ☐THERAPY ☐ MEDICATION SUPPORT SERVICES ☐CASE MGMT ☐ REHABILITATION ☐SUBSTANCE ☐CRISIS INTERVENTION

DOES THE CANDIDATE HAVE A PENDING MENTAL HEALTH REFERRAL? ☐YES ☐NO IF YES, PROGRAM TYPE: _____ IF ASSIGNED, AGENCY NAME: _____ PHONE: _____

MEDICATION COMPLIANCE: ☐TAKES REGULARLY ☐SOMETIMES TAKES ☐TAKES MOST OF THE TIME ☐NEVER TAKES ☐REFUSES CURRENT MEDICATION PRESCRIBED ☐NO MEDICATION CURRENTLY PRESCRIBED NAME OF CURRENT MEDICATION PRESCRIBED & DOSAGE : _____

PRESENTING ISSUE(S): (CHECK ALL THAT APPLY)	PRIMARY ISSUE?
MENTAL HEALTH DIAGNOSIS, SPECIFY _____	☐
MEDICAL, SPECIFY ☐ VISUALLY IMPAIRED ☐ HEARING IMPAIRED ☐ AMBULATORY PROBLEMS	☐
RECENT SUBSTANCE USE, SPECIFY _____	☐
COGNITIVE IMPAIRMENTS, SPECIFY	☐

		List Dates of Admission & Discharge	Name of Facility	Reason for Admission to Hospital/MH UCC
In the last 36 months, has the Candidate been admitted to a psychiatric hospital/MH UCC for a 5150 or received mental health services while incarcerated? ☐ YES ☐ NO	#of 5150's:			
	# of Incarcerated Mental Health Episodes	List Start & End Date of Service	Name of Facility	Describe services provided, provide diagnosis associated with services given, and P-Level at time of services. Please specify any 5150 during incarceration. List any FIP placement and include start and end dates.

Client **IBHIS #**

		Date of Incident	Describe Incident (Provide Name of Anyone That Heard/Witnessed the Incident)
In the last 48 months, has the Candidate had an act or threat of serious and violent behvaior toward self or others or attempts to cause serious physical harm to self or others? ☐ **Yes** ☐ **No**	**# of acts/threats/ attempts to self**		
	# of acts/threats/ attempts to others		

Please complete the information below in as much detail as possible, if more space is needed, please attach an additional sheet.

Describe candidate's **IMMEDIATE RISK & SAFETY CONCERNS** and most concerning behavior that occurred including danger to self and others

Describe how the candidate is **UNLIKELY TO SURVIVE SAFELY IN THE COMMUNITY WITHOUT SUPERVISION AND IS AT RISK OF DETERIORATION** (e.g. unable to care for self or provide food, clothing, or shelter)

Describe the candidate's **HISTORY OF NON-COMPLIANCE WITH TREATMENT** (has been offered the opportunity to participate in treatment and fails to engage)

If candidate is **CURRENTLY HOSPITALIZED/INCARCERATED** please provide details regarding candidate's current presentation/behavior while at facility **(TO BE COMPLETED BY HOSPITAL/JAIL STAFF ONLY)**

Client **IBHIS #**

FORENSIC: **(TO BE COMPLETED ONLY BY DHS CARE TRANSITIONS, DHS CORRECTIONAL HEALTH SERVICES CLINICIAN, DMH COURT LINKAGE, SUPERIOR COURT JUDGE OR PROBATION/PAROLE OFFICER)**

PLEASE SELECT ONE OF THE FOLLOWING: ☐ **MENTAL HEALTH DIVERSION (1001.36) CONSIDERATION TO AOT** ☐ **CONDITIONAL RELEASE TO AOT CONSIDERATION** ☐ **CANDIDATE CAN BENEFIT FROM MHS UPON RELEASE FROM JAIL** ☐ **FOUND INCOMPETENT TO STAND TRIAL**

IF INCOMPETENT TO STAND TRIAL: ☐ **FELONY** ☐ **MISDEAMENOR** **THE COURT DATE INCOMPETENCE WAS FOUNDED:** _____ **DEPT:** _____

WAS A SUITABILITY REPORT FOR AOT ORDERED? ☐ **YES** ☐ **NO IF YES, DATE REQUESTED:** _____ **DATE REPORT IS DUE:** _____ **NAME OF JUDGE REQUESTING REPORT:** _____

CURRENTLY IN JAIL:

BOOKING #: _____ **NAME OF FACILITY:** _____ **LOCATION AT FACILITY:** _____ **ANTICIPATED RELEASE DATE:** _____

NAME & PHONE # OF CARE TRANSITION STAFF THAT CAN ASSIST WITH CASE: _____

NAME & PHONE # OF CORRECTIONAL HEALTH SERVICES CLINICAN THAT CAN BE CONTACTED ABOUT CANDIDATE'S SERVICES WHILE REMANDED: _____